

Old Age Dependence on Family Support: The Effect of Health Insurance Intervention

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DECLARATION

I hereby declare that this thesis is a product of my own effort and has not been submitted for any degree or examination anywhere else. The ideas and theories of other authors have been appropriately recognized with references. All omissions are mine.

Name: Emmanuel Aboagye

Signature:

May 2012

DEDICATION

To my wife Tanja and little baby girl, Milana Abena.

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I am grateful to God who grants understanding to work. My deepest appreciation goes to those criticized the work and gave relevant comments where necessary to refine the work. My advisor, Trond Tjerbo, you were very supportive. I say thanks a lot. I am finally grateful to the elders who willingly participated to make the work complete. This work is for you all.

ABSTRACT

Old age population has increased and the family support is on the decline. The urbanisation of societies and constrained resources of families are seen as reason for the decline in family support. However formal social insurance is also known to give elders social and economic protection as well as better living arrangements in the future. The study examines how health insurance in old age affects family support for elders. Six cases studies were used to examine the relationship between health insurance as structure and elders as agents. Interviews and observation of informants were used as techniques to gather information. The case study observed that elders have reduced their dependence on family support. Less dependence on the family support was observed among insured elders. This does not mean the importance of the family is reduced. The declining dependence on family support is due to the complementary roles of healthcare provided through health insurance which influences interaction between the elders and their dependence on family support.

LIST OF ACRONYMS

DMHI	District Mutual Health Insurance
DRG	Diagnosis Related Group
FFS	Fee-For-Service
GOG	Government of Ghana
GHS	Ghana Health Service
GSS	Ghana Statistical Service
MHI	Mutual Health Insurance
MOH	Ministry of Health
NHIA	National Health Insurance Authority
NHI	National Health Insurance
NHIC	National Health Insurance Council
NHIF	National Health Insurance Fund
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
PCHIS	Private Commercial Health Insurance Schemes
PMHI	Private Mutual Health Insurance
SSNIT	Social Security and National Insurance Trust

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CHAPTER ONE: INTRODUCTION

1.1 Background

Ghana is predicted to witness the most rapid rise in the share of elderly people in its total population. In Ghana, the proportion of the elderly in the total population was 5.4% in 2005 and is estimated to be 14% in 2050 (UN 2005). These figures can be a challenge when family support for elders is also declining. This has led to the development of welfare plans for the aged and drafting of several national level ageing policy frameworks in Ghana (Ghana National Committee on Ageing, 2002). The plan of action placed emphasis on making certain social and economic security available to elderly persons. One of such plan of action is the National Health Insurance Scheme (NHIS) for elders.

For many years the family was considered as social security in old age in Ghana, where very weak social security institutions exist. However, the role of the family in the care and support of elders is declining. The decline in family support is due to the change in focus of people on their small families instead of larger ones and the growing economic constrain which makes it difficult for families to support elders (Aboderin 2004b; Ogwumike et al. 2005). This means many elders still remain poor and dependent.

Therefore the NHIS was introduced to promote health care for the poor and marginalised. Under the NHIS, medical costs are virtually free for elders. Before the health insurance intervention was the institutional Social Security and National Insurance Trust (SSNIT). The social security scheme was made to secure better social life and living arrangements for people that worked in the formal sector when they become old. The health insurance has similar goals as the institutional social security. However, the formal social security failed in paying entitlements to beneficiaries when they retire. The system also exempted people who worked in the informal sector to make contributions (Kaseke 1999; Boon 2007). The health insurance scheme includes elders both in the formal and informal sectors.

The research question is; how does use of health insurance in old age affects family-based care and support? There can be more than one expectation in this investigation. Family support for elders can decline as family resources reduce even further. It can also be that the family will provide more support for the elders due to the health insurance or there can be no effect at all. Another expectation could be that, elders can change their dependence on family

support as social protection increases with health insurance. Macro-level social theories are often used to explain the declining family support for elders. The macro-level theories may not explain fully the declining family support for elders. The case study joins the growing concern using micro-level social theory to explain the declining family support for elders. This case study guessed that health insurance can alter dependence on family support among the elders. If this was right, what implications will it have on other social intervention for elders?

1.2 Problem statement

The population of Ghana is ageing slowly amidst weakening traditional values. Family-based care that provides care and support to the aged have now reduced (Apt 1993; Apt 1996). The declining care and support from the family has left many elders without support and practical help of any kind. The condition of many elders remains impoverished with less social protection and poor living arrangements (Apt 1996; Mba 2007).

Through health insurance, the economic and social security in old age is expected to increase. Elders receive virtually free medical care from various health centres across the country. The case study wants to know how the health insurance raises economic and social security in old age and how this may affect family-based care and support for elders. The objectives of the study are as thus the following; 1) identify the primary caregivers and support for elderly; 2) identify the different social protection and security among elders; and 3) examine how health insurance affects family care-giving and support for elders.

1.4 Why the study is important

There is increased demand for both formal and informal care and support as the number of aging adults rise. In the developed western countries formal institutions are arranged to provide care and support for elders. The situation is different in most developing countries where informal family arrangements are predominant. The family are the security of elders in old age. Other formal social securities were also introduced for workers in the formal sector (Boon 2007). However this arrangement did not include the informal sector which employs most of the workforce in Ghana.

The high cost of health care made it difficult for the government to finance or rather subsidise health care (Jehu-Appiah 2011). The national health insurance scheme therefore emerged to help finance health care for all who would mutually contribute and benefit. This arrangement was in the long term to replace the out-of-pocket system and also provide a wide coverage to other sectors of the economy (Boon 2007).

The health insurance covers a wider population. It gives more security and support during ill health and replaces the out-of-pocket payment that was formally practiced. Persons beyond 70 are exempted from contributions and can receive health care.

The health insurance is an important supplement to social services that can be provided for all elders. Although the intervention has received support, there have also been criticisms of not covering the poor (Arhinful 2003; Jehu-Appiah 2011). This downside still makes the NHIS a useful measure of the benefit of social security schemes in old age. The reason is it has wider coverage than other social security in Ghana.

It is ideal therefore to examine the influence that the NHIS can have on family care and support for elders. This development becomes important as the number of primary caregivers per elderly reduces as well as social protection, when the families are no longer able to support the elders.

1.5 Structure of the study

The study is organised under broad chapters. The leading chapter opens as background to the study, problem statement and objective of the case study. The study also justifies the use of NHIS instead of other social security schemes available as the intervention policy in the study. The contribution the study is expected to make to knowledge is mentioned in the end of the first chapter.

In chapter two concepts will be defined. These are concepts related and important in aging studies. Reform in the financing of health care cost in Ghana and the health insurance scheme is described in some sections in this chapter. Theories will be discussed to aid explanation and give more direction to the study results. Mention is made of the modernisation and constrained resources views which explains the declining family support of elders. The social constructionist perspective is used to explain the influence of health insurance on family support through structure-agency interaction. This was to help explain

that elders are not passive but active agents in society and therefore are likely to relate with the health insurance intervention.

Chapter three is on methods and the study design. A minimal sample both from the urban and rural areas are used in the study. The selection of the six informants in the study is based on purposive sampling method. Some of the important variables in the study are; gender, residence, and living arrangement as well as other characteristics of elders that could be categorised. Health insurance which is the variable of interest is common to all elders. Therefore the study will compare the influence of health insurance on family care and support for all elders. The chapter also discusses reflections on the methods chosen and the ethics followed in the case study.

In the discussion and results chapter, the case study talks about the primary caregivers and living arrangement of elderly, and finally what happens to family support through the health insurance intervention. The last chapter is the conclusion and summary of findings from the study along with some implication of these findings on policy.

CHAPTER TWO: CONCEPTS AND THEORETICAL APPROACH

2.1 Population aging

The proportion of elderly population in sub-Saharan Africa is rapidly rising and these figures are expected to soar in the coming decade. The age group 60 years and above in the total population is currently 5% and projected to be 10% by 2050 in Africa (UN 2005). The growth in this age group is mainly due to changes in demography and also the transition in health. Aging of the population may therefore not be easily observable but subtly happens (UN 2002).

During the course of the demographic transition, births have declined while at the same time mortality is declining. This has brought important changes in the distribution of the population by age. In the long run, the result will be the proportion of the population under age 15 declining while the population over age 65 rises in the same period. Fewer mortality figures by and large will affect the age distribution much less than changes in fertility. The simple reason is that, reduced mortality affects all ages, while declining fertility affect just the number of new born into the population (UN 2005). Age dependency ratio measures the dependency burden in populations. This is the ratio of the population in the ages below 15 and over 65 to the population normally called the economically productive.

Old-age dependency ratio is the most important of the dependency measures. Old-age dependency when it increases raises the number of potential social security and protection recipients to the number of revenue generators through taxes (Fine et al. 2005). Thus, the higher the old-age dependency group, the more social security and protection programs needed to give assistance to dependent ones. Working family members not only have to take care of themselves but also the economically dependent elderly. Rather interestingly, Kinsella et al. (2005) finds that elders are financially and physically independent while the reverse holds for the working-age population without employment and income.

One obvious occurrence is the aged relying on family and social relations for support and help. Consequently, dependence on the young working force increases as there are more old people than the not old ones (McDaniel 2003). However, every culture has a way of describing the elderly and how they treat their dependent ones. For instance, biological ageing may not mean the same as social ageing. This differentiation may be clear in both

western and non-western countries. In non-western countries the aged are well cared for by family and relatives (Helman 2001). However this situation may be blown out of proportion as the economic transformation and modernisation occurring has brought reforms to health care especially for the elderly.

2.2. Health care financing in Ghana

Many reforms in financing the cost of medical care in Ghana have occurred in the past. The foremost can be recounted when the country adopted Structural Adjustment in 1980 as a way of economic growth. The policies in the adjustment aimed at cost recovery programs in the health care sector in the form of user fees. The government was therefore sharing the rising cost of health care with users. This strategy led to reduced access to health care with the adjustment strategy not bringing the economic development expected (Asenso-Okyere et al. 1998).

Yet health care costs were still high. The country needed efficient health care financing schemes. The Hospital Fees Legislation was introduced in 1985 and the ‘cash and carry’ system which effectively began in 1992. With these two schemes, a full cost recovery program had started. Therefore patients had to pay partly for consultations and diagnostic procedures. However patients had to make full payment for drugs supplied. The policy exempted from obligations of payment the under-privileged, people under 5 and above 70 years, leprosy, and tuberculosis treatment. This exemption was hardly practiced because of the difficulty in determining who is extremely poor and hospitals were also not reimbursed (Asenso-Okyere et al. 1998).

Non-governmental organisations also stepped in to support faith clinics and hospitals to finance medical costs (Atim et al. 2001). This support happened alongside budgetary allocations and the local common fund from the government. Therefore two financing schemes became operational in the country. These were private insurance and provider-based insurance schemes.

Private insurance are few and usually used by individuals and companies or groups (Osei-Akoto 2003). Employers use private insurance to pay for medical cost of employees. The company deducted premiums from salaries of employees to finance their medical bills. With the support of NGOs provider-based insurance began in some districts. This scheme

was started in 1995 on pilot basis (Atim et al. 2001). The provider-based insurance scheme was financed in the form of salaries and other administrative logistics from the NGOs and the state.

The population working in the informal sector usually used out-of-pocket payment to finance their medical bills. The family and other social networks help individuals who were not able to pay for themselves (Osei-Akoto 2003). The exemption fee for certain categories of people was still used in the provider-based financing. It was not until 2005 that a nationwide voluntary provider-based insurance reform was operational with changes in government. This was the National Health Insurance Scheme (NHIS) that covered those in the formal and informal sector of the economy.

2.2.1 The national health insurance scheme

The National Health Insurance Scheme (NHIS) in Ghana is a merger of traditional Social Health Insurance and Mutual Health Insurance. The scheme is administered centrally at the national level to collect formal sector contributions. Other types of health insurance schemes operating in Ghana are: District Mutual Health Insurance Schemes (DMHIS), Private Commercial Health Insurance Schemes (PCHIS) and Private Mutual Health Insurance Schemes (PMHIS). However, the DMHIS is funded with the National Health Insurance Fund but the rest are not (Government of Ghana, 2003).

The NHIS is financed from taxes both direct and indirect sources. Selected goods and services are taxed to form National Health Insurance Levy (NHIL). Social Security and National Insurance Trust (SSNIT) deductions and government budget allocations are all formal contributions to the fund. Contributions from the informal sector include annual premiums between GH¢7.20-GH¢48.0 per head based on income and ability to pay. No coinsurance, copayment, or deductible is required at the point of service. These contributions are supported with other funds like grants, donations, and gifts go into the National Health Insurance Fund (NHIF).

The NHIL from taxes accounted for about 61.0% of total income of the NHIS in 2009. Formal sector contributions made up 15.6% while the informal sector premium was only 3.8 % the same year (NHIA 2010). The NHIF provides funds for the scheme, subsidy for people who are not able to pay so that access to health services is improved. The scheme

is designed to promote social health protection through risk equalization, cross subsidization, solidarity, equity and quality care. The NHIS also reduces unexpected expenditure on health care and catastrophic spending among the insured. This brings financial protection to the insured (Nguyen et al. 2011).

The scheme exempts certain individuals from paying annual premiums. Children under 18 years, adults 70 years and above, formal sector employees contributing to the Social Security and National Insurance Trust (SSNIT) are exempted. Since 2008, pregnant women were also exempted after a free maternal care policy was introduced (NHIA 2008; MOH 2009). This has granted mothers access to virtually free antenatal, deliveries and postnatal care in many health facilities.

Like other insurance schemes the NHIS in Ghana does not cover all health care demands (NHIA 2008). Under the NHIS insured individuals can benefit when common diseases are presented at accredited health facilities. General out-patient and in-patient care, oral health, eye care, comprehensive delivery care, diagnostic tests, generic medicines and emergency care are also covered under the scheme. However specialized forms of care such as dialysis, organ transplants are not covered under the insurance. Services under government vertical programs for example antiretroviral for the treatment of HIV/AIDS, immunization and family planning are not supplied under the NHIS. Some drugs are also not listed on the list of drug that is covered in the NHIS. Claims made by accredited service providers are submitted to the district schemes for payment using the Diagnosis Related Group (DRG) rates for services and Fee-For-Service (FFS) for medicines.

This NHIS has received support from both insured and uninsured in the population. Many confess that there are benefits from the scheme and it helps to solve the problem of health care cost (Gobah et al. 2011; Jehu-Appiah 2011). Others criticise the NHIS as not covering the poor. Such trends have been seen in various studies. The very poor are not able to pay sustained contributions yearly and therefore do not benefit from the insurance (Asante 2008; Jehu-Appiah 2010). This may be due to less income of families or elders themselves. However, even the very poor pay contributions through value added tax when they buy goods and services (Boon 2007). In spite of this downside, the NHIS levels out the weakness in the social security scheme and gives right to health services. It makes it ideal to measure the effect that the NHIS can have on care and support for the elderly due to its wider coverage.

2.3 Formal and informal care for the elderly

Caring for older people has been categorized into two broad forms. One, formal care on one hand is provided by formal agencies or institutions. This form of care is paid for by the receiver and providers are normally trained professionals. Informal care on the other hand does not mean substandard care rather it is the care an older person receives from family, friends and neighbours. This can also be structured and with regulated processes (Knapp et al. 2002).

Aging can worsen health status and may increase the need for care and support in old age (Estes 2001). Such care is given to the aged in their homes or in organised institutions as substitutes. This is formal care. The assistance aged people are likely to receive include the everyday activities like bathing, dressing, cooking and cleaning. Other assistance includes skilled therapy to reduce the burden of illnesses and disability they suffer (Estes 2001). The organised care homes are mostly used in western countries. However countries differ in the organisation of such homes. While some countries have clear differences in choices of either formal or informal care, others practice a blend of the two.

The informal care is the assistance the aged receive at home from close relatives and the community. Informal care finds its roots in love, a sense of responsibility, a desire to be helpful, and receive praise for efforts. Others also give such informal assistance to acquire experience (Fine et al. 2005). It can be provided by someone who is not close to the care-receiver. This may be a voluntary assistance from an outsider. The nature of care can range from domestic help to personal care and support. This kind of assistance may go unobserved and unpaid for. However it is one of the most common types of care and assistance old people are likely to get. In the developing world, due to the importance of family, informal care for the aged from the family is commonly practised (Knapp et al. 2002). There has been an increasing surge in the provision of informal care in many developed countries by the family and volunteers (Fine et al. 2005).

Formal care and assistance has become relevant due to demographic changes, family composition, and labour force participation among drifting youth and women to the urban areas (Knapp et al. 2002). This raises issues of government support through health care mostly needed by the elderly. The financing of health care with such huge growth in elderly persons with increasing demand for health care is costly for governments and this is a

concern. In certain care tasks, formal and family-based care can replace one another. Family care giving is enjoying increasing recognition in government policy (Fine et al.2005).

2.3.1 The role of family in elderly care and support

The Ghanaian family is described in two broad types; the nuclear and extended families. The nuclear family which is the immediate family comprise parents and children. The extended family are close relatives that follow either matrilineal or patrilineal line. The extended family can also be a socio-economic arrangement between people, where the individual has duties, obligations and responsibilities outside the immediate family (Nukunya 1992). The extended family normally includes; brothers and sisters and their children, grandparents, cousins, nieces, nephews and in-laws. Within the family there are accepted norms and patterns of behaviour between the old and young (Apt 1996).

Traditionally the family is very important in Ghana. This evidence is so due to the culture of the people and weak social security institutions for the elderly (Gyekye 1996). The extended family was in the past like the current social security system. The family remain important for the elderly group (Apt 1993). In addition to three main functions of the family; procreation, socialization and economic co-operation, the more an important function is the care and support of the elderly (Nukunya 1992; Apt 1996). The support and care come in the form of food, clothing, medical care and costs, and in addition housing from their children or entire family (Apt 1996).

Other financial and psychological support that the elderly need is expected to be provided by the family (Aboderin 2004b). Especially support in activities of daily living for the elderly when they become increasingly frail and are beset with ill-health. Developed countries use both public and private sources to provide the support and assistance for the elderly. The situation is different for elderly persons in Ghana. Owing to few and weak institutional security systems, the family remains the main source of support and assistance.

Although care and support for the elderly are not neglected by the family, presently families are not able to provide for them. The family no longer give enough social protection to many elderly people (Apt 1993). It was unusual to find elders live alone. The common living arrangement among the elderly was to live in households with relations. These were mostly their children, grandchildren and other relations like; the sisters and brothers, nieces

and nephews, and cousins. However, in both urban and rural areas, one can notice elders who live alone (Apt 1996).

The Ghanaian evidence suggests there are many factors underlying the dependence of the elderly on family and the declining support and care from the family also. First, the modernization debate has not been left out as the reason for the situation. The traditional solidarity network, particularly the extended family is disintegrating because of modernisation and urbanization (Apt 1993; Gyekye 1996). Therefore the elderly population are left with little or no means of support and care. The ability of the family to offer support and care is also debated to be limited by scarce resources. Therefore families choose to prioritise on the younger groups to build them rather than use their limited resources on the already old (Aboderin 2004a).

Ogwumike et al. (2005) brings out an interesting result on the declining family care giving. In their study family care giving is based on value judgements from the children of the elderly. The children for instance base their support and care on the past conduct of their parent and give back to them in measure the care and support they deserve. If children consider the elderly was neglectful in the past, support and care also decline the more. The study sees more declines in the support and care for men than the women in general. The evidence in rural and urban Ghana shows that ‘retaliation’ affects above all older fathers, i.e. men, often leaving them exposed to a dependence on charity (Mba 2007; Aboderin 2004b).

According to WHO (2002) delayed child bearing among people these days account partially for the failing family support received by some older people. The simple analogy is an elderly person who bears children relatively late in life has to support the children even in his or her old age. This responsibility brings costs in particular of providing for the children’s education, despite their inability to generate income or draw on savings or investments. Therefore any support received from other family relations is more likely to go to meet the needs of the young children in his or her care, while the old person’s even basic needs are likely to suffer.

The description of the family is what a typical Ghanaian family is made of. The role of the family and the key importance the family plays in elderly care and support is mainly done by the adult children. The elders also play roles in the family as care takers, custodians of oral history and little house chores if they can do them. This may however differ from family to family as the children may not always be capable of caring and supporting their

elderly parent. In that case, the extended family is expected to take the responsibility of care and support of the elderly.

2.3.2 Social interaction

For the purpose of this study the social interaction approach will be adopted in studying the changes in care and assistance for aged in the family. Social relations can be understood as the way in which diverse groups of people are placed in relation to material and intangible resources. The social interaction not only includes issues of gender, age, class, and ethnicity but also determines people's roles and responsibilities which can change (Mikkelsen 2005). The relationships occur in a well set environment where institutions are organised. This environment is not stable but can change as time passes for instance, in an extended family set-up and community. Such interactional factors may be constructed through norms, roles and practices which guide how resources are allocated, duties and responsibilities shared, values given and power is mobilised (Estes 2001).

For instance, in particular communities, their conception and cultural knowledge on ageing can bring forms of relations which are forms of assistance and care for the elderly. The choice of health care to use and the forms of arrangements for care in old age can be explored using the social relationships. The very old persons may need someone to make choices for them in terms of care and support (Knapp et al. 2002). The social interactions approach can help explain the place of social relation and culture which can affect dependence, trust and even living arrangements.

When people age certain forms of living arrangements can be made. They can choose to be alone or with the family. The focus on social relation is vital because the elderly usually live with their extended families throughout the older years. Living arrangements, particularly in the developing world, are received through family support systems and have major implications for well-being of the elderly. Therefore living arrangements such as living alone, living with a spouse only, and co-residence with adult children have vital consequences for older persons (Mba 2007). The trust an elderly person has in their family can lead to making a choice on living arrangements. The community's social relation informs the very nature or type of care, support and dependence in old age groups.

2.4 Care and dependence

Care is a natural activity from one person to another, normally between persons of certain relationships. Need must be displayed by the one receiving and response from the care giver. In the past the burden of care was evidently undertaken by women (Kittay 1999). The need for support and care can arise in old age. Care is provided formally or informally by relatives and others. There may be arrangements made to give support and care so that loneliness is reduced to the barest minimum if not totally removed from society.

However “dependence” most often used in elderly care can have a depressing import (Kittay 1999). Unlike care one cannot think of dependency as a normal social condition for all. There are several differentiated types of dependency (Baltes 1996). All these types of dependence tend to occur in old age. The types of dependence include; life-cycle, physical, psychological and political dependence. In addition is economic, financial and structural dependency. Dependency is influenced by several factors ranging from individual traits to social structures (Baltes 1996).

Certain major influences tend to increasingly deepen dependency among the old age groups (Fine et al. 2005). On one hand is the obligatory early retirement among the working class which increases need for support when they retire. Similarly low incomes which are legitimised and the construction of community services for recipients who are not actively involved in setting up such social services are part of the reasons for the increasing dependence among the elderly. According to Townsend (1981) it is the structures in society that have created the continuing dependence of the elderly on the family and this burden for relatives can only be reduced with the same structural reforms.

Another argument also points to the fact that ways in which a range of daily activities are measured also influence our idea of dependence among elderly (Baltes 1996). These measurements are medically-based and the ability of an elderly person to perform these activities is influenced by the social environment of the elderly. However, such measurements are confounded by the assumption that dependency is an individual characteristic rather than a social relationship (Fine et al. 2005). This argument therefore suggests that the behaviour and perceptions of all the actors contribute to the state of dependency.

The need for care may not necessarily be a cause of dependency (Fine et al. 2005). These two concepts can have common place. However they have places they diverge and also

converge in meaning. Caring for an older person can be a reaction to dependency. Dependency is clearly demonstrated by someone's need for help and assistance. This need for help and assistance is met through providing care. Therefore care itself can influence and deepen dependency.

Dependence in this study will be understood as when elders do not have the ability to support themselves in one way or the other. This means that elders cannot support themselves through own income, savings, pensions, and are exposed to poverty. It is when the elderly is in such a situation, that the main responsibility lies on the family to meet the needs of elders. The study chooses this definition of dependence in old age which follows Ogwumike et al. (2005) definition. According to them, older people can become dependent on support from their families due to sudden retirement, redundancy or death of a spouse.

2.5 Social theories of aging and analytical approach

Theories in old age studies are divided under broad arbitrary categories. The distinctions are between micro and macro-social levels of analysis (Bengtson et al. 2009; Pierce et al. 2010). Micro-social level theories on one hand are individual-based. Therefore the individual and his/her social interactions are the main focus. The macro-social level theories on the other hand examine social structures or structural elements as they influence experiences and behaviours. Some social processes that are studied among elderly operate on both micro and macro levels (Bengston et al. 1997; Bengtson et al.1999).

2.5.1 Modernisation perspective

Modernisation theory is a macro-level theory. This perspective has been the main stage for describing the changes in family support for the elderly in both the industrialised and the developing countries (Aboderin 2004a). The decline of older people's status and roles due to the breakdown of the extended family and shifts towards the nuclear family explains the decline in old age family support according to the Modernisation perspective. These changes in roles and preferences for small family sizes are all results from the urbanisation and industrialisation of society.

Recently several case studies stress the role material constraints play in the declining family support for the elderly in developing countries (Apt 1997; HelpAge International 2002). In these studies, the material constrain notion are used as counter explanations to the family systems breakdown idea, from the modernisation notion, as causing the decline in material family support for the elderly. However according to Aboderin (2004a), the material constraints idea has increasingly been cited in developing countries alongside the modernisation model to explain the declining family support for elderly.

Both modernisation and material constraint notions fail to fully explain the declining support of the family to the elderly (Aboderin 2004a). The modernisation perspective does not consider the role that material constraints play in the decline of family support. It focuses on changes in roles and norms and the resulting decline of family support. The material constraints notion also does not recognise the role of values and norms as influencing the decline in support. Both explanations do not marry well the inter-relationships between material and social changes (Aboderin 2004a). This gives the micro level theory, social constructionist perspective, which considers such interrelations between interventions and reducing family support the more appropriate explanatory guide in this case study.

Other micro theories such as critical theories, life course perspective, social exchange theories and in addition feminist approach are less relevant to the study (Bengtson et al. 1997). All these are micro level perspectives or can be both micro and macro but for the sake of brevity our attention is drawn to the social constructionist perspective which can render explanations for our data and fit well with the research.

2.5.2 Social Constructionist Perspective

Social constructionist perspective of aging reflects a long tradition of micro-level analysis in the social sciences focusing on individuals and social behaviour within larger structures of society. This has a link with the structuration theory in social sciences on how society and the individual interact. According to the structuration theory social change occur when social structures and those that make up the society interact. Giddens is formally associated with the structuration theory. This perspective recognises both the structures and actors in the system and what changes can be brought in human lifestyle (Giddens 1984; Giddens 1996). This

approach criticises the humanistic and structuralist approaches that says the structures and actors operate and change society separately without any interaction between the two.

The structure and actor concepts are interdependent and recursively related. The social practice of actors are not free of the social structures but draws on these formal and institutional structures which may be rules or resources (Bengtson et al. 1997). The structures therefore drive human activity to produce and reproduce practices such as caring for another. Giddens put it this way, 'we create society at the same time as we are created by it' (Giddens 1984 pp. 14).

Structures include political, economic and authorized institutions in society. These institutions set the rules of patterns of behaviour commonly seen in society. The relation between structures and actors is one enabling but can also constrain the human activity. When structural properties are enabling it becomes both the medium and outcome of social practices. Constraints rather limit capacities of the social activity. This can close the many alternatives open to social activity (Giddens 1996).

Social actions are what people can do in the faces of socially constructed structures (Bengtson et al. 1997). The actions of people can be individual actions but more so a collective way of thinking. The behaviour and reaction of people to structures differ from place to place. The locale with similar forms of socialisation and social rules can create and re-create actions people become familiar with. Social actions are normally contextual of the life of a place.

The theory in general explains what can be a multifaceted interrelationship between societal process at the micro level, the formation of public policy, and the well-being of the aged population (Bengtson et al. 2009). It demonstrates how social processes can shape old-age policy and in turn shape the experience of the aged population or our definition of who an elderly person is. How the interactions between social processes and old-age policy can have differential effects on different subgroups within the aged population can also be interpreted within this perspective. The effect of larger social forces such as modernisation and urbanisation on the elderly population and how individuals through exercising agency can shape the very social structures that in turn shape their social context are all within the framework of social constructionist perspective.

The study is approached taking into consideration the structure and actor behaviour interaction. From the interaction comes out the changes and actions people demonstrate. The structure is represented in the study as the health care and the insurance scheme. One can ask

what is in the health insurance that can influence family-based care and support as our hypothesis states. The health insurance, which is virtually free, is both social protection and provides health care for the elderly. This makes it an important social intervention through public policy (Nguyen et al 2011). Individuals in the study can respond to the established social protection scheme in differing ways. The result of the interaction helps to interpret changes health insurance brings in the relationship between elders and their family.

There is a process of interdependence between individuals and the structures. Through this we can understand that agency is embedded within social structure (Bengtson et al. 2009). The approach is also useful in the sense that it lends itself to many areas of research in social sciences. The approach is supported by other perspectives such as critical theories and the life course perspective (Baars 1991). However social constructionist theoretical perspective of aging has not been left out of the criticism in literature. First, the social constructionist theory makes unclear the macro-level effects such as cohort, historical, and age stratification influences when the individual level is given much attention in the analysis (Bengtson et al. 1997). Therefore using social constructions often minimizes the role of social power and less attention may be given to social structure (Baars 1991).

How is the social constructionist theory able to explain the expectation in the study which is how the use of health insurance in old age affects family-based care and support? In the social constructionist theory, the health insurance and the family can be explained as macro social level structures. The elders are the agents and are at the micro level of social interaction. The family is described as a structure because it is also a social security arrangement for people in old age. Using the social constructionist theory means the attitudes of elders that will be observed in the study are shaped by the health insurance intervention. This creates other influences on support from the family through the interaction between elders and the intervention. As already mentioned earlier in the introduction, on one hand, family support towards elders can further decline or the opposite can happen. On the other hand, the theory assumes elders are active agents. Therefore, it can also be that elders may alter their dependence on family support as their social protection increases with health insurance intervention.

CHAPTER THREE: STUDY DESIGN

3.1 Method

Qualitative research is able to answer questions and unravel social problems that quantitative methods may fail in doing (Grbich 1999). For instance queries that investigates the ‘how’ of everyday behaviour and situations are suitable using qualitative methods. This method is often criticised as not scientific, not reliable, biased, and too subjective and therefore has less validity in the result it produces. The method also uses only a small number of subjects which makes the findings in the end not transferable to other places (Kvale et al. 2009). The claim of non-transferability of sample study which is also often contestable will be discussed later in section 3.2.

This chapter broadly lays out the material used in gathering information for the study which is interviews and observation of cases. As well the study area and procedure for selecting cases are described in detail. The reliability and validity of the instrument and study results are discussed. Finally, ethical procedures followed and critical reflections are also discussed in this chapter.

3.1.2 Interviews

One of the instruments used to get necessary information was interviews. The interviews followed a question guide. A lay meaning of interview is to exchange views through conversation. Interviews have been one of the important means for collecting information in case studies. It gives information and ideas of people to understand the content of their everyday lives and to produce knowledge (Yin 2009). Some ethical issues surrounding the exercise are also important to adhere to when conducting research. This makes interviewing in research go beyond the usual conversation between two or more people (Kitchen et al. 2000).

The type of case study interview used is the focused interview. Informants were interviewed for only once in a short period of time. The interviews were conducted in a conversational manner but followed guided questions. The advantage of conducting interviews in this way was the ability to encourage and engage informants in conversation to

enrich the quality of the outcome. More important was the ability of focused interviews to substantiate evidence that is perceived to be already established (Yin 2009). However it was time consuming.

The semi-structured interview guide used had mainly open-ended questions and few closed-ended ones. The questions in the interviews were prepared with predetermined themes. Some of the questions were also constructed during the conversations. The questions that came up during the conversations differed based on the informant being interviewed. This is called semi-structure interview (Kvale et al. 2009). The interview in the study was directed with a guide that focuses on certain important issues.

The use of semi-structured question guide in collecting information made it possible to change the order and form of questions. Therefore every informant could be asked more questions when interesting and peculiar issues arises in the conversation. This led to a wide range of issues being covered through discussion (Crang et al. 2007). However, the demerit is that important issues may be lost accidentally as the researcher gets swayed by the most interesting events. This can limit the ability of comparing responses especially when interviewing people with different backgrounds. This was not an occurrence in this study because informants were always brought back to the guide so that discussions were not misguided.

The study used a designed interview guide with most of the questions open-ended. The guide was framed using the research question. The questions focused on how attitudes towards family-based care and support may be affected with the introduction of health insurance. The questions were in sections and carried different but related themes. Each headed section had sets of questions to bring out information on an interested theme. The themes that were included in the question guide were; social protection and living arrangements, self-support, health insurance and changes in family-based care. The basic information of informants was also among the themes in Appendix 1. Basic information of informants covered: age; gender; marital status; occupation; and residence.

3.1.3 Observing informants

Observation was another tool used in the study to observe overt or covert informants to generate information and ideas about them. Observation can be done mostly through the participatory or the direct means. In participant observation the researcher is fully involved in the everyday unfolding of the events in the study setting. Direct observation involves observation of issues which are sometimes difficult to get information on for instance; behaviour types and social conditions (Yin 2009).

Direct observation was used in all cases during the interviews. This method was useful in acquiring additional information. I was able to observe the social status of informants. This included for instance their housing conditions since I got the chance of being in their homes. The strength of connection between the elderly and the family or caretakers was also observed. I was also keen on observing the activity level of the informants. By activity level I mean, how elders are able to do everyday activity with or without support.

There were demerits in observing informants. It was quite a difficult task. This practice demanded that I knew the culture and other social activities of the people. This was not a problem for the interviewer. However during observation, the informant was sometimes put under stress if they were aware of being observed and they behaved differently. For instance, some elders did not want to accept that they are weak and cannot do one thing or the other. However, it could be seen by observing how strong or weak they seem to be. But there were still challenges as observing informants did not give them the opportunity to say something about their environment and their way of life. This can paint a different picture of the ways of life of the people being observed. The resulting outcome will therefore not be reliable (Crank et al. 2007).

3.2 Rigour in method

The quality of the research design was tested using Yin's (2009) criteria for qualitative case study. Validity and reliability of the research can be categorised using these four criteria; trustworthiness, credibility, confirmability and dependability. The methods used in information generation and analysis were tested with these criteria.

In establishing construct validity two main principles were followed. The study used multiple sources of evidence during information generation. These principles include; the use of more than one method and recording events surrounding the interviews and the interview itself. The additional method used in this study was observation of informants. Both sources of gathering evidence are discussed in sections 3.1.2 and 3.1.3.

Woodhouse (2007) sees triangulation and documentation as the way to establish construct validity using semi-structured approach. The use of different methods, informants and different investigators to generate the needed information is known as triangulation. The different methods of investigation applied in each interview are used to test the working hypothesis. This procedure is continued until available and additional interviews generate information that confirms or disconfirms the working hypothesis.

Recording what informants said and observing the context in which the interview happened is known as documentation. The practice of recording was important since the question guide was modified for some interviews. Recording was essential to establish validity. The idea was that response and understanding of what informants say can differ within the characteristics of context in which responses are generated. In Mikkelsen (2005), comparing different comments of informants on particular questions in semi-structured interviews makes it important for investigators to reflect on their influence on the interviews, and conversation pattern between informants. This practice of documenting and reflexivity enforces rigour in a semi-structured approach. The reflections on the study and interview environment are discussed further in the last section.

In a case study that seeks to establish causal relationships, internal validity must also be tested. In Yin (2009) internal validity can be achieved through effective handling of data and analysis. The cases selected in the design were also matched using cross-case technique. The technique combines two strategies in the analysis. The study explained the proposition using cases and theory as well as addressed all rival cases. This technique was relevant since the study consisted of more than two cases. In using cross-case synthesis transcribed text was used to create tables. The tables show data from individual cases under similar description. The selection of comments and observations from the data are brought under related broad themes in a table format. The themes were formulated from the research questions and objectives. Each interview was systematically categorised and analysed to bring out more meaning in the data (see Appendix 1). These were the tactics the study used to achieve internal validity.

In Lincoln and Guba (1985), the transferability in qualitative research is the level at which generalisations can be made of the study to other places. In Crang and Cook (2007) researchers may not achieve external validity since personal interests, positions, and biases are also displayed in data gathering. However the external validity of the study can be enhanced through the research design (Yin 2009). In this study, the replication of the study was also aimed at through the selection of multiple cases and to boost external validity. Multiple cases were selected using the diverse case selection method to enhance external validity. The diverse case method for selection of cases is discussed further in section 3.3.1.

Reliability refers to consistency of the research outcome (Crank et al. 2007). The work can be said to be logically consistent when ways through which results are arrived at is understandable and also when other researchers can arrive at the same conclusion. In terms of how dependable the data is, a database for cases was kept so that the arrival of the study's conclusion is understood by readers (see appendix 1). In order to reduce misinterpretation of informant's responses on the variables in the study, 'members check' was used (Crank et al. 2007). Informants were made aware of what they have produced and permission was also sought from them to use direct quotes in the report writing.

3.3 Study sample - informants

Case studies are intended to provide understanding of happenings in a larger population (Yin 2009). The selection of individuals of interest that will represent the population is important. The sample in case studies is generally small by description and random sampling may be of no use. Therefore the number of individuals selected to participate will be unrepresentative. This makes the sample selection in case studies a difficult task (Gerring 2008).

In the study, 6 informants were included. There were 3 cases in the urban and 3 cases in the rural areas of the same region. The research question of the study made it possible to select cases that reproduce characteristics of the population and also provides difference along the dimension of theoretical interest.

3.3.1 Procedure for selecting informants

The non-random purposive procedure was used to select informants for this study. There were many characteristics in informants that made the selection of informants cumbersome. One of the decisive factors used was the age of the informants. The study was interested in elderly who were of the age 65 years and above. Informants included both men and women who were in this age group.

Second to selecting informants was other indicative criteria such as; elderly person with or without family support. Family support is the first social resource an elderly person can have. This was necessary to know elderly persons living arrangement. In addition, social protection like the health insurance and formal social security can determine the elderly person's participation in the study. Other resources and social background of the informant will also give varying experiences on the form of support and social protection that an elder can obtain. The purposive sampling procedure used could be criticised for being too simplistic and subjective compared to other sampling techniques. However, the method became relevant because of the characteristics and appropriateness of the group being studied.

Therefore the diverse case selection method which is a purposive sampling method was used in the selection of informants in the rural and urban areas. In this method a set of cases were selected as described above. Since the variable of interest which is health insurance was categorical by definition, all other explanatory variables on the outcome were also categorised (Gerring 2008). However cases differed both in the variable of interest and on other variables such as family size and social status for instance. Therefore because of the diversity within each category the chosen cases were typical in family care giving and level of support.

The diverse case method was chosen because of its capability to handle differing cases within categories and also explain the outcome through the different cases. The method covers all the relevant range of variation in cases. In this way it enhances the representativeness of the variability in the population (Gerring 2008). Therefore using diverse case method the study has a stronger claim of representativeness than other non-random sample methods used in selecting sample for case studies. However, this does not solve all selection method problems. The empirical generalisation of the results to population cannot

be solved with the diverse case selection method. The variability in the population may not be fully represented even though there was variability in the selected cases used in the study. The reason is due to the degree of variability among the population which are uncertain.

The variables in the case study as mentioned earlier were elders with differences in gender which were male and female; different residence that were urban or rural; as well as different characteristics that could be categorised. For instance elders were either living alone or with someone in types of living arrangements. The similarity the study expected elders will have in common was the health insurance. Therefore the study could compare the influence of health insurance on family care and support from those different cases through the cross-tables in Appendix 1.

The case study over-sampled and informants that did want to be part of the study for any reason were not included. Other ethical challenges in the selection of cases are discussed in section 3.7. In the end three cases each were selected in the urban and rural areas. At least two cases each for elders who had formal social security beside the family and those without formal social security were also selected. These selected variables were also used as controls on the dependent variable which is family-based care and support. All informants used in the analysis had health insurance except one who also had formal social security from the retired work. All these characteristics and differences were combined in the tables (Appendix 1), to investigate the proposition of the case study.

3.4 Study area

The study was conducted in Ashanti region in Ghana. The region has economic importance in commerce, transport, agriculture and small-scale industries. The region is the most heavily populated and rapidly growing in the country. The population represents 19.5 per cent of the country's population which is currently a little over 24 million (GSS 2009). The share of elderly in the population is also the highest among all the regions. The proportion of the population aged 65 years and older increased from 2.5 per cent to 3.0 per cent in 1960 and 1970 respectively. By 1984 the elderly population in this region had grown to 3.6 per cent. This age group had increased from 6.1 per cent in 2000 and by 2010 was expected to exceed 6.3 per cent (GSS 2009).

The region is mostly urbanised with high populations. A contributory factor to the high urban population in the region is the growth in places which were previously considered rural settlements. These growing places have now attained urban status through populations and development spills. However the region still displays wide disparities in urban and rural areas in terms of health care, social and economic activities (GSS and GHS 2009).

The NHI is more entrenched and coverage is wide in this region (NHIA 2009). More interestingly, the reform of capitation in NHIS has started a pilot in the region to evaluate possible changes that can be made to scheme to benefit all. The capitation also aims at reducing congestion at the major hospitals and also controls losses to the fund. The outcome of the pilot program if found acceptable will lead the way for implementation in the country (NHIA 2010). The region is more suitable for the study for reasons such as the demographic characteristics it exhibits. More so culture values towards the elderly and the feeling of belonging to family is held high. This makes the problem of the study at hand more present in the area. There is evidence of more elderly people and the declining family-based care and support as well for many elders in the region.

The next choice was whether the study setting should be in rural or urban areas. Several studies have been conducted on the elderly in the few care homes in Ghana. Some studies have been done separately in the urban and rural areas on ageing. There are big differences in these areas concerning access to resources and support. In the past, the practice was the elderly relocate from the urban areas as they age to rural areas where they came from. This resettlement plan is done to ensure that the elderly at all cost receives family based care and support. Recently, some elderly people move at will from urban to rural areas for the social protection and arrangements for living. This may differ in elderly persons who are in the middle income group. They choose to stay in the city because of their connection with their property and social ties in the urban areas.

In this study, a mix of urban-rural setting was used. This is due to complexities of relocation of the elderly. This urban-rural mix choice will make the study more of a comparable nature. The choice is also certain to provide a wider discussion and views instead of a one-sided view of the problem if urban areas are chosen over rural areas or vice versa.

3.5 Recording interviews

In order to prevent misrepresentation and uninformed comments recording conversations was helpful. Recording was made with Sony microcassette-corder M-450. This machine had capabilities of using both electricity and batteries. It also has sensitive properties which gave clear voice recordings. All voices including the interviewer were recorded on micro-cassettes that records for 90 minutes. On the whole, each interview lasted for 45 minutes with only a few lasting for more than an hour.

The place for interviews was also important for recording and the informant. Places that were calm and serene were used. The reason was to get clear recordings and reduce intimidating presence that would hinder informants from telling me their story. Also I needed such a quiet place for the interviews to make transcribing the work a bit easier. In most cases, interviews were held in the homes of the informants. These are places they felt they were more comfortable. I had one interview with an informant in her workplace where she traded in goods and services.

Clearly explaining to informants what the outcome of the study will be used for was important for them to participate. The outcome I explained was going to be used only for academic purposes. This cleared doubts about what the outcome they generate is meant for. They were confident and willing to be part of the study. No pictures were taken of participants in this study. This was an ethical issue the researcher encountered. There are more of the ethical issues discussed in section 3.7.

3.6 Data analysis

Data analysis is combining strategies and techniques to draw conclusions based on observed evidence. Yin (2009) mentions different strategies and techniques that can be used to examine, categorise, and workout outputs to draw conclusions in case studies. This study made use of two strategies and one technique to help in analysing the data. There was no computer-assisted tool used in the process.

The technique used was the cross-case technique that combines the two strategies in the analysis. This technique was relevant since the case study had more than two cases. The tables in the appendix show data from individual cases under similar description. The selection of comments and observations from the data are brought under related broad themes

in the table. The themes were formulated from the research questions and objectives. Each interview was systematically analysed to bring out meaning in the data.

The first strategy used to start the analysis was relying on the proposition of the study. It was more convenient to use the proposition as a guide to case study analysis. The research proposition gave the study direction and made the data more organised. The direction it gave on the numerous conversations recorded was to focus on certain parts of the data and ignore others (Yin 2009). The proposition was what the objectives, questions, and design of the case study was based on. Therefore, attention was drawn to answering the question and objectives of the case study. The analysis began with transcribing recorded conversations.

The other strategy used in the analysis was to examine rival explanations from the cases. The combination of this strategy with the one based on the proposition in the study strengthens internal validity (Yin 2009). The design in this study was a multiple case study design. This makes analyses of rival interpretation important. The study drew cases from the urban and rural areas. The aim was to study how health insurance intervention among the elderly population can affect family care-giving and support. However social status, place and individual differences instead of the health insurance intervention can give explanation to changes in the outcomes (Yin 2009). All such contradictory accounts in individuals were fully covered and analysed to make the conclusions more convincing.

Guided interpretation ensued from the transcribed interviews which were later made into the table. Similarities and differences in family care giving of the elderly in Kumasi and Kumawu were finally made bare for further analysis. Commentaries and parts of whole conversation were also used as relevant quotes in addition to interpretations to help draw conclusions. The concepts and analytical approaches talked about in the previous chapter were applied to support such interpretation and make conclusions connected with theory.

3.7 Ethics and reflections

Every case study is associated with ethical issues that apply from first stage information gathering to final stage report writing. Research ethics is to make clear the agreements the researcher enters in with the subjects. It involves getting the informed consent of the interviewed, the observed and those who answer the questions. An agreement about how data

gathered will be used, reported, and disseminated as information or knowledge should be made aware to the subject of the study (Yin 2009).

Informed consent is pivotal in qualitative study (Crank et al. 2007). Informants were aware of what they are contributing to and their position in the study. First elderly people who could not give their own consent to the interview were not included in the study. Then, informants who wanted to withdraw or not answer certain questions for any other reason were told they could do so. Before ending interviews, participants were asked whether their views could be quoted directly during analysis. At the end of the interviews topics that I found particularly interesting were brought up to ensure that participants confirm their response to such questions. This gave me an opportunity also to discuss my interpretations with them.

Some information gathered from interviews was treated with caution. Some of the information that came up in the interviews was privileged and needed carefulness with use in the report. The confidentiality of information gathered through the interviews and observation were also kept. The data was only stored on my personal computer which had a password. The information gathered was used for research purposes only. Moreover, informants were given pseudo names in the analysis and all informants remain anonymous in the case study. Permission was also sought from the Norwegian social science data services through the question guide. The study was given a go-ahead if the researcher was to follow the ethical issues and question guide submitted to the Norwegian social science data services.

Finally a case study of this nature can lift the expectation of the informants. That is their expectation as to what happens after the research (Mikkelsen 2005). This is an important ethical issue in research which is about promises and reciprocity. Promises must be kept so that the informant will also feel they have gotten something back (reciprocity) in what they put in the research. Informants were not promised things the researcher cannot give back when the research was over. Informants were all made aware that the study only carried educational substance and nothing was expected back in return.

In every conversation the position of the interviewer to the interviewee was reflected upon critically. This was done to ascertain the influence of the relationship on information produced by the informants (Dowling 2002; Moser 2008).

First, the social characteristics I possessed were what I reflected upon. Social characteristics like age and gender defines my position as researcher. These characteristics were significant during my encounter with the interviewed and evoked cultural norms and

behaviour patterns that may have affected ideas informants shared (Mullings 1999). For instance, gathering information about the position of the elderly and the kind of social protection and security. This may have raised eye-brows about exactly who I am. In this case a clear introduction of who I was to my informants was helpful.

The current debate on ‘insider-outsider’ position regarding how researchers may gain access to information was also important to ponder on. The ‘insiders’ say that they have an advantage to more privileged information because of their affinity with the group they study and thus have also the benefit of giving much more meaningful interpretations to opinions shared by respondents. The ‘outsiders’ also argue that they are likely to get such privy information since they may be considered neutral and also are likely to be more objective to observe behaviours without any distortion (Mullings 1999).

Considering this scenario, although I am from this region in Ghana and know more about the culture of the people living here, which may make me an insider, I may still be considered an outsider. I do not belong to the elderly group. The outsider position claimed does not give me an opportunity. However I looked for opportunities where knowledge sharing became effortless by building trust and seeking co-operation from informants through rapport (Mullings 1999).

Therefore an ‘outsider’ from a different culture, age, and sex (female), for instance from Europe or other parts of Africa, can achieve similar result in this case, but bringing on personal interest and biases can affect the results.

Last was what informants say and whether they mean what they say. The informants can give some information and practice otherwise. This can be a situation where the elderly may not want to talk about things he/she thinks is so private. Some elderly may not want to “wash their stained linen in public”. This made me reflect on the way to design the questions. The open-ended semi-structured interview guide made it possible to ask further questions to verify what informants really mean what they say or do. Observing their environment and communication gesture was used to capture things they may not talk about.

3.7.1 Methodological Challenges

There are shortcomings in the case study. The limitation was on the part of the study design. However strategies are used to reduce the effect these biases can have on the study results.

The sample was quite small. The case study used only six cases from the lot interviewed. The small sample selection reduces the ability of the case study outcome to be generalised about the population. The diverse case method and the multiple case study design was one of the ways to solve this bias. This case study design was chosen to strengthen external validity of outcomes and make the results generalisable to the population. However the diverse case method does not completely solve empirical generalization of the result to the population. The variability in the population cannot be said to be fully represented even though there was variability in the cases used in the study. The empirical generalisation of the results to population could not be solved the method because the degree of variability in the population was not known.

Another shortcoming was an ethical challenge. The problem especially was with which informants to interview. The reason was age was described as chronological. This choice does not address the differences among the elderly. For instance an 80 year old can be active and thus less dependent on family care and support than a 70 year old who is weak. Thus chronological age did not bring out the differences clearly among the elderly. However, other background information and characteristics in them were also used to help in the analysis.

The age differences brought some challenges in using observation as a method for gathering information. The activity level of elders was something that was observed and also asked in the question guide. However, in the observation some elders that looked weak and frail tried to portray themselves as strong because of the presence of the researcher. This could have influenced the results. But since the same observation was also captured in the question guide, the researcher could confirm their claim from their answers to the questions.

Other limitations were time and resources. The informants were only interviewed once after making appointments with them. The expectation was to conduct series of interviews including observations so that validity is enhanced. All these efforts were constrained by the resources available to the researcher.

CHAPTER FOUR: ELDERS' DEPENDENCE ON FAMILY SUPPORT

4.1 Case studies

The informants used for the discussion in this chapter are the 6 elders selected through the sampling method. All the cases were recorded over one month in the field both in urban and rural areas. The informants selected for the analysis show rural and urban differences, gender differences as well as different socio-economic backgrounds.

The case study examines how health insurance affects family care and support for elders. The cases are used to determine forms of protection and security for elders; living arrangements and primary caregivers of elders; and finally to explain how the use of health insurance, if perceived to be social and economic protection, could affect family care and support for elders in the region.

The discussion is a case by case analysis of the interviews for each informant. The discussions were conducted under broad themes. Some of the themes that were discussed include: social security for the elders apart from the family; importance of health insurance; primary caregivers and living arrangements in old age; and as well the dependence of elders on family support. The difference between ages of the informant was also used in the discussion. The table of analysis in the appendix was very useful for the analysis and discussion.

4.2 Social security beyond the family

The extended family is an established important system in the Ghanaian culture. For most elders, the family functions as social security in old age (Apt 1993). Support and care for elders are provided by the family (Apt 1996).

The study wanted to know what elders lean on in old age as social security apart from the family. It was to help solve the first objective which was to find out whether the elderly have other forms of social security apart from the family when at the same time family support is said to be declining (Aboderin 2004b; Apt 1993).

There were questions asked that led to the ensuing results. Informants responded to questions on possession of health insurance; and whether they find health insurance important, as well as gave their personal view on health insurance as social and economic security in old age. The discussion includes two cases that were receiving social security pension benefits. The discussion of the cases is both for urban and rural areas.

4.2.1 Importance of health insurance

The possession of health insurance was very important for all the informants in the study. The district mutual health insurance and the nationwide health insurance are both voluntary policies. It is therefore not compulsory for everyone who chooses not to be part of the health insurance and pay for medical care. However, it was only one case out of the six who did not possess any form of health insurance.

Wofa living in Kumasi is 78 years old and visits the main hospital when sick. He sees the national health insurance as necessary and important. He says *“...it is a national commodity that everyone must have. Moreover the health insurance dwells on the number of people registered to operate, as they say: in numbers we have strength”*. The mutual health insurance scheme is strengthened when more people register to be part of it. Other reasons cited to support his view of the possessing as being important was the benefits one receives from health insurance. Wofa mentioned that his expenditure on medicals has become very expensive since he became ill and had problems passing urine. This has made his expenditure go up. *“It was good the health insurance came to us now to help. At least it covers part of my expenditure on health care”*, he says.

Other informants also make similar comments about the importance of the health insurance to them. Although they all mention similar reasons like Wofa other common reasons were; that the health insurance is a protection for unexpected illnesses. It was also obvious that the elderly with health insurance use their coverage also for their grandchildren. This gives them sense of responsibility and they also feel they have contributed to their grandchild's health care cost.

“It was necessary that I have health insurance. I do not go to the hospital very often. It was necessary for me and my grandchildren. You never know when sickness will come. These days the mosquitoes are all over. You can get malaria or fever anytime as they continue to

bite you. If you have the health insurance and something suddenly happens you can seek medical care''. Manuwaa is 80 years old and lives in Kumawu.

The only case that did not have health insurance also recounted that health insurance was important and a necessary intervention: Opanin Nkosuo is 83 years old and is without health insurance. He lives in Kumasi and benefits from pension salary. He thinks the health insurance is very good. The economic freedom it brings from medical bills is the good part he sees. *‘‘It is important that everyone gets it’’*, he mentions. He mentioned that he had started the registration process to get health insurance. He had only forgotten to return to the authorities for his health insurance card. Nkosuo however is a pensioner and he gets pension benefits every month.

Conclusion

The study finds that health insurance is important and necessary for elders both in urban and rural areas. The reasons are health insurance can be a precautionary measure towards an event of illness and also provide economic freedom. For instance, the virtually free medical care that elders and their families get if they are health insured is important to them. This is how elders are coping with health insurance social security in old beside their families (Apt 1996; Nguyen et al. 2011). Moreover some old people who had grandchildren said that having health insurance can help them contribute in the health care of their grandchildren. This is because the scheme covers persons under 18 years old.

4.2.2 Social and economic security in health insurance

The discussion on health insurance as social and economic security was to determine the security characteristics in the intervention. It was also to investigate and establish health insurance as security in old age just like the family. Questions on the social and economic security characteristics were sequel to whether the informant was insured.

Previous studies mention old people with formal social security are less dependent on family care and support (Kaseke 1999; Boon 2007). Therefore knowing the characteristics of health insurance and the protection it gives to the insured was important for understanding the findings in this study.

For all informants being insured against sickness was in itself a social protection. There were some informants who however disagreed on the economic incentive of being insured. The disagreement was because being insured although is a protection but nothing reflects in your pocket. Some comments on evidence of social and economic security in health insurance were; medicine free of charge, no unnecessary discrimination among the insured, instructions on blood pressure levels as well as protection for insured and the family were commonly cited. There was additional evidence given by case studies.

Opanin Nkosuo has six children who are all grown up and well educated. They are in the Kumasi while he lives in a rural area, Kumawu. He and the wife are separated. He is 83 and living alone. Opanin Nkosuo does not have health insurance. He rather depends on the pension salary that he gets every month to pay for medical bills in the event of illness. He rarely gets sick and therefore rarely seeks medical treatment. The last time he was sick, he still used the pension salary to pay for all his medical treatment and clinic stay bills. He admits health insurance works in the same way as the social security for pensioners who had worked in the formal sectors. Nkosuo had started the registration process to be insured. He thinks that if he was insured the last time he was sick; there were some economic incentives he would have enjoyed from health insurance.

There was another case that retired from work in the formal sector and had health insurance. Wofa is 76 years old and has 6 children remaining. He lives alone but very close to his sister and son who often visit him in Kumasi. According to Wofa, no one knows when sickness will come, whether today or tomorrow. Sickness can rear its head anytime. It does not matter whether you have money or not, so everyone has to be prepared. He thinks that is the aim of health insurance and being insured. Wofa also mentions that the illness he suffers from makes the cost of medicine very high. The health insurance covers some of his expenditure. He said he does not ask of other family members for support. However without the insurance he would have worried them and his family may even run away from him because he always wants something from them. He would have depended on his sister and children. He may end up becoming a nuisance. The insurance according him has provided some protection for him by bringing the family even closer and in terms of money for medical treatment.

Maa Adwoa is 71, married but lives alone with her house help. She sells groceries and has only health insurance but no other social insurance. *‘Because I have health insurance I can go to hospital when I need health care. If someone who is not your own even wants to*

help you they will ask whether you have health insurance. When people realise that you have health insurance and you are sick people will be willing to take you to the hospital. The taxi fare may not be a problem, but the medical bills can hinder them from helping if you have no insurance. If I am not well and alone without money I lay there and die. Before I was insured, I waited to get assistance and money before I show up in the hospital or clinic. Now things are not like that. It was really necessary for me to get insured. You never know when you will get sick. It can happen anytime, so you should be prepared''. The preparedness that being insured gives her in the event of illness is a social protection for her and the little girl that lives with her. Maa Adwoa also takes care of the family with the money she makes from selling groceries. The little girl and the husband who is older than her are her responsibility. She mentions that things would have been difficult without health insurance.

Abra unlike Maa Adwoa is 72 years old, not married, has 3 children but lives with a little girl who is a house help. Abra mentions that she has a health condition that makes breathing difficult for her. Therefore she needs to be extra vigilant and have some protection around her. Her situation does not give her anytime to wait and feel well. She just has to go if she can or if she cannot, must get help to go. Moreover the price of the medicine she uses is very expensive. Health insurance did not cover at all the medicine for patients with similar health conditions. However some of the medicines are now covered under the health insurance. She mentions that she gets enough treatment and care when she goes to the clinic. Abra does not see any improvement in her income but the insurance helps her. The medicine she uses is expensive and are partly covered under the insurance; it helps her to save some money. She clearly stated that she could not afford all those medical expenses in the past without seeking help from someone especially her children. But the situation is different for her now with insurance.

Manuwaa is 80 years old, has 9 children and lives with her daughter in Kumawu. According to her, being insured is the reason she is still alive. She does not work presently and her children pay her medical bills. Health insurance has reduced the economic burden on her daughter who takes care of her. She commented that the “cash and carry” system was not good compared with the health insurance. With health insurance she does not always have to pay all medical expenses and this reduces the burden for her daughter. Even though sometimes health insurance does not cover certain services it is better for her than to pay for all services. She mentions an example from the last time she went to clinic: ‘*the medicine the*

doctor prescribed for me was not covered by the insurance and I had to pay for it either in the hospital or buy the medicine from pharmacy''.

Opanin Kofi, who is 85 years old, has 4 children but lives with the grandchildren in Kumawu. He admitted that being insured is both a social and economic protection in old age. He reiterates that the insurance is a protection for him in times of sickness. He does not work and the grandchildren provide for him. With the health insurance he has both health care and protection in terms of paying medical bills which the grandchildren who are not working themselves may not be able to support. Opanin Kofi admitted that at first he had to pay each time he went to clinic. Now he does not pay at all and has also been fortunate to get all his medicine free of charge from the clinic.

Conclusion

Like the formal social security, the health insurance intervention is characteristic of providing protection for the elders that are insured (Nguyen et al. 2011). Elders that were not even insured admitted that their experiences would have been different if they had health insurance. For some elders it brings the family closer to them and also reduces the economic burden on children and grandchildren who take care of their elderly ones. This finding is also true and it confirms Kaseke (1999) and Boon (2007) studies on formal social security. The preparedness elderly people who are insured talked about, was the ability to access health care whenever they need it. The economic incentives are present but may not be seen. However, the savings that are made when the insurance covers medical bills are pointing to the economic security in health insurance. Therefore being insured brings to an elderly person social and financial protection as well as makes them self-reliant. This is a finding similar to Nguyen et al. (2011) work on the protection effect of health insurance in Ghana.

4.3 Primary caregivers of the elderly

In addition to other functions such as bringing forth and helping those that need financial assistance, one important role the family plays is the support and care of elders (Nukunya 1992; Apt 1996). This is in Primary caregivers are those who support in activities of daily living when elders become increasingly weak and cannot do many things on their own. This section identifies the primary caregivers of elders; their needs in activities in daily living; and the kind of support they receive from their primary caregivers. The needs in daily living were taken from the Activity of Daily Living (ADL) score in appendix 1.

Abra is 72 years old and feels she can do everything. She cooks as well as sweeps, bathes and dresses herself. Walking is not a problem and she walks without using any support. She does all the house chores with the help of a house helper who she adopted as grandchild.

“Sometimes, before she even returns from school I have already done everything. I can say I do not need help at all but it is good to have someone around to help. I have not reached the stage where I could not do things on my own. May be I can say I cannot pound fufu or perhaps carry heavy stuff”.

Abra does not consider the extended family as her primary caregivers. Rather her son is the one she relies on. The son is married and cannot have Abra in his home.

“I will count on my son for help when there is the need. Sometimes when I get asthma and my condition is very bad, he comes to stay or comes to me every day. I can also count on this grandchild I have if she listens to me and wants to be here. If the parents will agree to let me have her forever then she can also help. As the saying goes, do unto others what you want others to do unto you. I have taken good care of her and I will expect that she reciprocates it in the same way if she wants to live with me. However if she decides to go, I cannot keep her forever. I will bless her and then she can leave”.

Her children, two daughters and a son are housing her in Kumasi in a rented apartment. The children have also arranged to take care of the girl who lives with Abra. The children of Abra are also providing food, clothing, medical bills beyond the health insurance and other necessary things.

Daily activities like dressing, bathing, eating, and doing a little bit of cleaning and sweeping is not demanding for 76 year old Wofa. He walks without using any support but

gets tired easily. Therefore he does not go out very often. It is his son who comes around, cleans and washes for the elderly father. Apart from the son, Wofa has a sister that works and provides food and other support for him. He feels that: *“... it is expected of my children to be responsive to my care and needs. I can rely on my children for help when it is needed. There are other family members who live abroad and although they are all away, when I need help they help usually financially. They are all doing what is expected of them”*.

This is another story of 71 year old Maa Adwoa in Kumasi. She is married but the husband lives separately from her. She lives with a house helper. She was first asked about her activities in daily life and this was what she had to say.

“At this age, I do everything all by myself. I am not totally weak and frail that I can’t do anything. I can cook, dress up, and bath. Washing is difficult for me. It takes a lot of time to wash but I do it in bits and gradually and I will finish. Carrying heavy things like water is impossible for me. I cannot do certain things alone, that is why I have this small girl with me. She helps with so many things. I send her on errands and she can’t even cook. So I have to do so much myself even though she is here with me. But because I have no one my situation is very sad”. Maa Adwoa feels she needs help always.

Q: what about your extended family?

“I have a family. But it is God I count on when I need help. The family is nothing. My family members do not even know me and they don’t come here. If you have no children you have no family. I live here with people who come from the same village as me. We are just friends and they care more about me than my own family. It is God I depend on all the time not man. If this little girl I live with decides to go away one day, then that is it. She is someone’s property but I take care of her right now. She also serves me but if she decides to go I can’t say no”.

The bitter sounding Maa Adwoa feels the family has neglected her because she does not get support from them. Close friends and the little girl she houses are those she relies on for support and care. The husband is also old and needs attention from Maa Adwoa. The grocery store she operates is what provides for their daily needs. However she still thinks that when she is too old the family will be helpful to her since she had no children.

“I can do everything myself”, says Nkosuo who is 83 years old. He feels that he is still active and can even cook but allows the niece to do it for him since it is tradition. He however admitted that, although he can cook he cannot do it routinely. The only activity that Nkosuo cannot do is for example taking water to the bath house. With these activities the

niece is there to help mostly. Nkosuo's niece is the primary caregiver and she supports him with food and in other activities.

Again, Opanin Kofi who is 85 years old does not have so much to do around the house because he is a man. The preparation of food and sweeping in the compound and house is normally the work of the women. He lives with two grandchildren. The granddaughter does all chores at home. *‘It is my granddaughter helps me with stuff like carrying water to the bath house also’*, he says. However, Opanin Kofi can bathe and dress up on his own. He goes out to walk and exercise which he thinks is good for his health. The grandson is the primary caregiver since he provides for them. Opanin Kofi gave the grandson farmland so he will bring home food, buy clothes, medicine and other necessities from the produce they sell.

Table 4.1: Elders primary carers, living arrangement and support

	Gender/ Age	Primary caregiver	Living arrangement	Support from family
Urban				
Maa Adwoa	Female (71)	House help	Alone (with house help)	None
Abra	Female (72)	son	Alone (with house help)	Pay rent Money for food Provide clothing Medical bills Other things
Wofa	Male (76)	son	Alone	Other things
Rural				
Opanin Kofi	Male (85)	grandson	grandchildren	Provide food Provide clothing Medical bills Other things
Opanin Nkosuo	Male (83)	niece	Alone	Provide food Other things
Manuwaa	Female (80)	daughter	daughter	Pay rent Provide food Provide clothing Medical bills Other things

Source: from case study interviews, 2012.

Manuwaa is 80 years old and lives with her daughter. According to her, every activity is difficult for her to do. She can't walk and the doctor has advised her to walk around all the time for exercises. All household activities are done by the daughter. She tries to bath and dress up, and eats with no support at all. But someone has to help with water to the bath

house. Manuwaa feels she needs support and care all the time. It is her daughter who is her primary caregiver. The other children help with providing rent, food, clothing, and other necessities. The other children do not live with them but they monetise care and support and send to their elderly parent, so that the daughter uses the money to support her.

Conclusion

The family, especially the children, remain the primary source of support in old age in both urban and rural areas. The family ties and support still existed. The kind of activities an old person could not do differed and was not always associated with the age as expected. The study shows the different activities of daily living that old people could not perform that needed support and assistance. Support was usually tied to the needs and inabilities in the daily life of elders. Support with food, clothing, paying medical bills, and in addition housing was common. Children who could not support and care for their elderly parent directly monetised their support and assistance. In some cases a house helper or one of the children took the responsibility of care and support. Elderly men receive support from the family and in some cases from children. However elderly women receive support and assistance usually from their children (Apt 1996; Van der Geest 2002). This outcome is in line with Apt (1996) and Mba (2007) work on the primary caregivers of the elderly and the gender differences in support and care for elderly men and women.

4.3.1 Living arrangements in old age

The family role of care and support is important as already mentioned due to the weak social security institutions in Ghana (Gyekye 1996). Since the family is no longer able to or perhaps reducing support and care for elders, certain changes must be identified in the living arrangement of elders. This section first identifies how the elders live. Living arrangement is defined either as alone or not alone.

The study found differences in the living arrangement of elders both urban and rural areas. The living arrangement of elders in Kumasi was likely to be living alone. This situation was more likely to happen if the person is not married. Their children who are mostly the primary caregivers for elders in the urban areas were married or perhaps actively working.

This means their parents could not live with them or perhaps elders do not want to live with their children. Apt (1996) finds similar results in the coping strategies among elders in Ghana. The children that are mostly primary providers for their elderly parent may give support and assistance away from their homes. Support and assistance could also be from house helpers who are arranged by the children of the elderly to live with.

There were two elders in Kumasi who also lived alone but were assisted by house helps hired by children or elders themselves. Both cases are elderly women. There was a third case; an elderly man who also lived alone had support and care from the son and sister who lived closer to him. He was however not dependent on the family because he was active and a social security pensioner.

The living arrangement is different among elders in the rural areas. In Kumawu, one of the elders lived with the daughter; the other with grandchildren and the last was living alone. Interestingly, elders in the rural areas may have lived and worked in the urban areas in the past. However when they go on pension or cannot work anymore, they retreat to rural areas where they are sure of getting support and assistance from the larger family if not from their own children. This is mostly the case of elderly men who count on the larger extended family for support and assistance rather than their own children.

Both Opanin Nkosuo and Opanin Kofi are elders around the same age (see Table 4.1). They had lived and worked previously in so many places. They decided to return to their maternal extended family in Kumawu to get assistance and support with some activities they cannot perform. However Nkosuo still lives alone while Kofi lives with the grandchildren. The difference between them is that, Nkosuo had pension salary every month which he depended on. Therefore it was his niece who only comes around and cooked for him.

Where could the difference in living arrangements emerge from? An earlier thought was that, due to the social security Nkosuo enjoys in the form of pension salary, he could afford to live alone. Clearly, Nkosuo is less dependent than Opanin Kofi who is supported by the grandchildren. There is another explanation for elders that are more likely to be living alone. The question was asked among some respondents if they knew any reason for some elders living alone and mostly without support. Their answers were in line with Ogwumike et al. (2005) results. That is, children usually neglect their elderly parent who showed some bad conduct towards them in the past. For instance it can be issues of neglect of responsibility of the elderly parent in the past towards the children. This was also common in the work of Van der Geest (2002).

It should be known that this is more entrenched in families that inherit the matrilineal way. In this way, elderly men who conducted themselves badly towards the children may also be neglected because the children do not inherit from his line. Therefore children leave the support and assistance responsibility in the hands of the extended family their elderly father belongs to. However this explanation did not apply in the case of Opanin Nkosuo and Wofa who even though lived alone, mentioned they supported their children. The explanation of elders with enough resources and social and economic protection being less dependent on the family is more applicable in their situation.

Women can also be neglected and have no support and assistance. However, these cases are rare. Maa Adwoa who lives in Kumasi with a house help is a case of an elderly woman living alone. She never had children who could have supported her in old age. But she is hopeful that the extended family will not neglect her when she needs support and assistance. Like Maa Adwoa, Abra expects the children to support her in old age.

Conclusion

The common living arrangement of elders was to live alone. This was predominant among elders in the urban areas, although the study also found elders living alone in the rural areas (Apt 1996). The children, grandchildren and other relations like; the sisters and brothers, nieces and nephews, and cousins who were mostly their primary caregivers do not accept full responsibilities to live with the elderly like in the past. The situation of living alone among the elderly was deeply entrenched among elderly men (Van der Geest 2002; Mba 2007). Women who live alone were most often sure of getting support from their children or the extended family. Moreover men both in the urban and rural areas with high social and economic protection also could be found living alone like Kaseke (1999) and Boon (2007) also establish in their studies.

4.4 Dependence on family care and support

The main and last objective of the study was to explain how using health insurance in old age affects family care and support. From the build up so far, the case study has come to the following interesting results.

First of all, the evidence from study that family ties and support still exists. The family, especially the children, remain the primary source of support in old age in both the urban and rural areas. Support can include one or the entire list. Food, clothing, paying medical bills, and housing were the most important. Secondly, although it is true the children of the elderly are still the primary providers of support and care for their old parents, living arrangements had changed.

Lastly, elders both in urban and rural areas agree on the importance of being insured for precautionary reasons and reducing high medical cost. Moreover, the study is able to establish that health insurance is an economic security for elders. The intervention provides social and financial protection for the elderly who are insured (Nguyen et al. 2011). Therefore how will health insurance affect family support for people in old age? Is it the family that will reduce their support or otherwise, the family become closer to elders? Could it be also that elders will reduce their dependence on family care and support due to the policy intervention?

The discussion following uses the social constructionist perspective to explain the resulting changes as interaction between the elders and the health insurance intervention and perhaps the family. Health insurance intervention for elders in the study is described as the social structure. The agents on other hand are the elders (Bengtson et al. 1997; Bengtson et al. 2009). The change in attitude of elders towards support from the family is discussed for insured and uninsured elders.

From the role of the family especially from the adult children the kinds of care and support elders need are identified. It is the need for care and support that can also make them dependent on the family. The cases are used to examine before and after changes that has occurred for insured elders and elders without health insurance.

These three cases are elderly males who had worked in the formal sector and had formal social security beside health insurance. According to Wofa, health insurance helps him get enough treatment within the year and also medicine. All though his attitude towards going to the hospital has not changed, health care is more accessible with health insurance. Concerning the family, their relationship is still intact and the support he gets from them has not declined. However Wofa feels less dependent on the family for financial support. As one who does not work and must depend on others for support, he thinks the burden on the family has reduced further with the insurance on health. Otherwise, Wofa knows he would have been heavily dependent on the family for support because of his ill-health and also because he does not want to use his pension salary now. In the past when the “cash and carry”

system was the procedure to get health care, he would have been more dependent on the family since it was cash down for services in hospital.

Similarly, Nhyiaeso who has not been drawn in the discussion so far had formal social security. He is 70 years old, married and has seven children. He lives with the wife and children and the same people are the primary carers. They support with activities around the home and all other things he cannot do himself. Beside the social insurance and pension benefit, Nhyiaeso also had social health insurance from the work place. However this was taken away when he went on pension and depended on the working wife for financial support. He then became constrained because he had children still in school. It was therefore a relief for him when the health intervention came and he quickly switched to the national health insurance for health care. The health insurance has reversed his dependence on financial support from the wife and others. Nhyiaeso was able to support his children in school because his health care expenditure is reduced. He also mentioned that he does not depend on pension income before accessing medical care. *‘The social security pension salary is small and usually delays in reaching pensioners. Things would have been difficult without health insurance after the social health insurance was taken away from him’*, he says.

On the contrary, Opanin Nkosuo who also had formal social security and receives pension benefits had no health insurance. The health insurance would have freed him from paying medical and hospital stay charges when last he fell sick. This would have been a financial protection for him he believes. Therefore health insurance can reduce dependence on the family or primary care givers even further for elders with formal social security.

The rest of the discussions are on health insured card holders without formal social security. An elder like Maa Adwoa who lives alone with a young house help thinks health insurance has changed her relationship with the family. She ask no one for help when she is sick. The little she makes from the grocery she sells is not spent on health care. This means she can save and use resources on other things her family needs. She also believes that with health insurance someone will even dare to help your way to the hospital, but without it no one will mind you because they may have to pay medical bills which are burdensome.

Health care is more accessible with health insurance to Abra. Her reason is that, there is nothing to pay for after seeking care. She could not go without money in the past but it is nearly possible for her these days. Her attitude towards the health insurance is positive and she does not wait for support from children before seeking medical care. Moreover, the state

of her health does not allow her to wait for financing before accessing the hospital. Therefore not only does the insurance grant access but as well she can take decisions on when to seek medical attention. Concerning support from the family, Abra thinks it has reduced because she demands less.

Manuwaa is health insured. She is especially content that her children are relieved from paying huge medical bills when she is ill. According to her, costs of health care make her dependent on the daughter. Her children still come close to her and relate with her. However because Manuwaa is physically weak, she depends on her daughter even with health insurance. Her attitude towards health services had not changed since she cannot even go out as much as she wanted. However she goes to the clinic whenever she has an appointment for medical check-ups which has become frequent for her. She could not have done this without health insurance. This has ensured enough monitoring of her health state and she gets less sick. Moreover each visit is informative for her. Sometimes she goes for physic-exercises which help her to be strong and less dependent on the daughter even when she walks.

Likewise, to Opanin Kofi being health insured means less bother to grandchildren who are not working with paying health care bills. He thinks his grandchildren do not have to support him any more with health care expenses. He frequents the clinic more than before the times he had health insurance. This is because he has more access and also takes decision on his own. The education and information he receives at the health centre makes him feel better and strong with less ill-health. However, the family remains important to Opanin Kofi because of the enormous help and assistance he needs in everyday living.

Conclusion

In the study, elders become dependent on family support through activities of daily life, during decision making, and especially lack of resources to function without help from others. However, the increasing state of elders depending on the family has been partly undone with health insurance intervention. With virtually free health care, elders enjoy a relatively improved health state due to increased access. An improved health state means less dependence in terms of financial support and assistance. As well, elders are learning to stay healthy in old age with information from health centres they visit. As in Baltes (1996),

financial dependence is just one of the many faces of dependence. However, this can lead to all other faces of dependence in old age. These faces of dependence are further discussed in the next chapter.

Again, since decision to seek medical care usually was based on whether you could afford health services, the children and family had the power to decide for the elders. With the intervention elders now decide on their own, and do not have to wait these days for the “green light” from their support providers. Most of the people in old age have changed from the wait-and-see behaviour to check-now attitude with health insurance intervention.

Lastly, with fewer resources the elders remained dependent on the family and their children resources. These resources from the children as already mentioned were food provision, clothing, paying medical costs, and housing. However the health insurance takes off one of the items on the support list which is medical cost. Elders react to this change by saving on medical expenses and they are able to free resources for other necessities and become less dependent in family support.

CHAPTER FIVE: DISCUSSION AND CONCLUSION

5.1 Declining dependence on family support

The declining dependence on family support was evident from the comments of respondents. Responses like: ‘‘I feel less of a burden for them’’; ‘‘I don’t ask them for support’’; and ‘‘I don’t bother them these days so much’’ are pointers to reducing dependence on family support. The ‘‘them’’ informants mention refers to the children or family that the elders depend on. This case study explains the declining dependence on family support from the relationship between the health insurance intervention as the structure and actors who are the elders. Through the social constructionist perspective, our understanding of what may be happening is rather elders reducing their dependence on the family support.

According to the modernisation theory, the decline of family support in old age is due to the breakdown of the extended family. Their explanation is that elders do not get support from the family due to breakdown in the extended family. People want to concentrate on their smaller families. Even so, the elders will still have families to belong. This means the family still exist. We realised that women are more likely to get primary care from their children than the men. The men are likely to fall on the extended family in old age for support. This means the family, be it extended or nuclear, where elders get assistance still exist. The modernisation view can therefore makes the understanding of changes in family structures clearer than point out interaction affecting the decline in family support in old age.

When the resource constrain view was also brought into the debate, it was said that family resources were dwindling leading to the decline of family support for elders. Therefore families prioritise support towards the younger generation and give less to elders. This idea has more of an economic and material support role of the family. However this is not the only role the family plays in care and support for the elderly. There are others which are physical, psychological and all round care and support. If elders are not getting the material support there will obviously be a decline in support from family. But the elders are not passive agents in society. They have to look elsewhere for support and protection in whatever form it comes. Other sources of protection beside the family can be formal social security for elders who were employed in the formal sector and the health insurance

intervention. However, since a larger share of elders was in the informal sectors, the major source of protection apart from the family is the health insurance.

It is this interaction between policy intervention and the agents, and the resulting decline of dependence on family support that the social constructionist idea brings to bear in this study. The policy intervention is the virtually free health care through health insurance. This structure was created for the poor in society to raise their social status. Many elders are poor and have few resources. Therefore as active agents it is expected that elders make use of the policy intervention, therefore the outcome of the study which is the decline of dependence on family support and care. Elders who are already not getting enough from their families are falling on the intervention and through that reducing their reliance on the family. This outcome is what the modernisation and constrained resource perspectives may not succeed to explain well.

This is not to say the health insurance intervention is an improved replacement for family care and support. The family is important and the case study recognises it. From Table 4.1 one can identify the primary caregivers of elders. These primary caregivers are the same family members, both extended and nuclear. This means the family still plays a major part in the support of elders even though their role is declining as many elders live alone.

The importance of the health insurance intervention cannot be overstated to relegate family support and care to the background. Both social resources are used by elders to make them less dependent. The family is still needed since health insurance alone as mentioned earlier in the study cannot guarantee that there is a decline in all the faces of dependence. However the study notices less dependence among elders especially on financial, economic, and physical support.

5.2 Differences in level of dependence in old age

The types of dependence include; life-cycle, physical, and psychological dependence. These are the many faces of dependence as was mentioned in section 4.4. In addition is the economic and financial dependency. All these types of dependence tend to occur in old age and are influenced by several factors including social structures (Baltes 1996). In the study dependence was found to be different within and between age groups.

The elders who were between 65 and 75 years old and still active are more likely to be less financially dependent on family support. This may be so because of the reduction in their spending on medical costs and the savings from fewer expenses. Those in this same age group who could work were much more independent than those who did not work at all. Within this same group, elders with ill-health and are also not working may be dependent than elders without ill-health. However elders who had formal social insurance and health insurance felt were less dependent on financial support from the family.

The other age group were elders beyond 75 years old. These were more likely to be financially and physically dependent. In this category, elders needed physical support with daily activities almost all the time including financial support from the family. However, financial dependence was declining since their primary carers also felt expenses on their medical costs has gone down. Moreover within this same group, elders have information on physical everyday activity from the health centres which makes them learn to be less dependent on family care. Mostly care has also shifted to formal health care centres for these elders in this age group.

This means dependence on family support among elders may not decline in all the faces of dependence. However there are declines in financial, economic and in some cases physical dependence on the family mainly due to the health insurance intervention. The elders in the case study decry capitation reforms in the health insurance on a pilot in the Ashanti region. They feel this reform is able to reshape their position and gradual independence they are gaining from family support. Elders complain some clinics do not accept patients with health insurance since clinics are not reimbursed on time.

The health insurance intervention had improved the social protection of the elders in the urban and rural areas. Most of the elders were without formal social insurance. The family set-up was and still is social protection for old people that is almost breaking down. With all these changes, particularly the changes in the family do not favour the elders. They prefer to use resources at their disposal, for instance the health insurance. This has enabled them to reduce their reliance on family support. This change is possible when it is known that social interventions can alter the behaviour of agents, and also being aware of the many faces of dependency (Bengtson et al. 1997).

5.3 What happens to family support?

The interaction between elders and the health insurance also had effects on the nature of family support. The family is important in old age. They are primary care-givers, and also support elders in many ways importantly with activities of daily living. The study observed how the interaction between elders and the health insurance affects support from primary care-givers, the nature of support received from the family, and living arrangement of the elders.

It was previously stated in the analysis that the family, especially the children, remain the primary source of support for elders. The family ties still exist even though support for elders is on the decline due to diminished resources of the family and not because of the health insurance intervention. The effect that could be observed was the balance between demands by the elders and support giving from family. The demand for support from the family had declined as was noticed in the study. It was the health insurance intervention influencing this new relationship between elders and their primary support givers and the entire family.

The level of support and assistance elders received from their family also say a lot about the family and elders after the intervention. Support was mainly food provision and clothing, and in addition housing from the family. There were also evidence of support and assistance that were monetised. Although there were gender differences in support and assistance, evidence still remain that elders were getting what they need if the family could afford it. The effect of the interaction between elders and intervention on support from the family was the demand for support from the family that had declined.

It was evident that living alone was becoming common among elders. It was common among elders in the urban areas than elders in the rural areas. Living alone was deeply entrenched among elderly men. It could not be easy said that the health insurance alone could have altered the living arrangement of elders. The occurrence may be due to several other factors such as the social status of the elder. The changes in family set-up could also explain why elders live alone. However the change in the family set-up was the reason elders would depend less on family resources when presented with other beneficial social interventions.

This study points out that the effect of the intervention goes beyond the benefits. With family support reducing in recent decades due to constrained resources and urbanisation, elders will need support from other sources including health insurance. This intervention can

also make elders less dependent in old age and reduce pressure on families. However, the family will remain important to elders in support and care. The reason is that, it is not all elders that can be completely independent of their families. Some elders need the support and care of their family because of their health state and their inabilities. The difference in age and levels of activity of elders are critical determinants of family support.

5.4 Formal care alongside family-based care

Aging can increase the need for care in old age. The nature of care can range from domestic help to personal care and support. Care which is paid for by the receiver in their homes or in organised institutions by trained professionals is formal care. Informal care especially comes from the family and can also be regulated routines in daily life to help elders (Estes 2001).

Formal care as described is uncommon in the areas where the study was done. The most common type of care for elders is the informal care from the family which are largely not paid for. Due to the importance of family, care for the aged from the family is commonly practised. The health insurance was introduced to provide healthcare to elders who are beyond 70 years at virtually no cost to them. This is because there are few institutional care centres that gives care to elders and the family remains their main source of support and assistance.

The main goal of the health insurance for elders is to provide health care through recognised health facilities. This is very important as the family cannot provide this professional care and assistance. The responsibility of healthcare providers towards elders has increased with the introduction of the health insurance. The main responsibilities of care of these healthcare providers include; advising elders on medicine and the type of food to eat, giving regular check-ups on health status and guidelines to everyday exercises to make elders less dependent on support from others. This increased role of the health services due to the health insurance is in many ways similar to what an institutional care home will provide.

However from the roles of the healthcare provides it can be observed that family-based care has not been completely taken over by the formal care. Presently, families are unable to provide care for elderly due their decreased resources and less people to care for them. However this does not mean the family has neglected care of the elderly. It is the

amount of care which is no longer enough for elderly people. The efforts of the family are therefore complemented with healthcare provision from the health insurance intervention.

Family-based care is still increasingly recognised in care for the elderly. However in certain care tasks, it can be observed that the formal and family-based care replaces one another. This brings improvement in family-based care for the elders. It is also the complementary role of formal care that influences the interaction between elders and their family. This interaction leads to reduced dependence of elders on family support.

5.5 Summary and conclusion

The case study examines the influence of health insurance intervention on family care and support for elders. The study was motivated by the evidence that family support for the elderly are declining in developing countries. Some studies have cited reasons such as the disintegration of families and dwindling family resources as influential factors for the decline in family support. However with protection in old age through policy interventions such as health insurance, elders could decrease their dependence on family support.

The main question was to investigate how health insurance in old age with increased social and economic protection could influence family care and support. In all, six informants were used to examine the interrelationship between health insurance as structure and elders were also considered as active agents. Informants were selected non-randomly through the diverse case selection method in the urban and rural areas. Interviews and observation of cases were conducted to get information. The results from the case study were drawn from case by case analysis of all selected cases. All rival explanations in the cases were also included in the discussion. Based on the informants, the investigation concluded with the following findings.

The health insurance was necessary and important social protection in old age. The main reasons were that health insurance serves a precautionary measure towards an event of illness and brought economic freedom. Health insurance made elders better prepared with health care becoming more accessible. Therefore elders that were insured were more self-reliant as well as had better family relations (Nguyen et al. 2011). This finding was important as it pointed to the social and economic protection health insurance gives in old age.

Another interesting finding that was confirmed in other studies was on the living arrangements among elders. The common living arrangement among the elderly was usually living alone in urban areas (Apt 1996). Living arrangement was however different for elders who were still married, as they were more likely not to live alone. The story differed in the rural areas as some elders continue to live with their family especially the extended family.

In spite of elders living alone the family, especially the children, remain the primary source of support in old age. Elders are supported with food, clothing, and in addition housing. It was also common for children who could not support and care for their elderly parents directly to monetise their support and assistance. This meant another person is tasked with the responsibility of caring and support. Elderly men usually receive support and assistance from the entire family while elderly women receive support usually from their children. This finding confirmed that family ties and support still exist although elders may live alone. Moreover, elders confirm of support from children and the family be it little or huge. Therefore the explanation of the decline in dependence of elders on family support could probably be influenced by the health insurance intervention and other social resources at their disposal.

The ultimate finding from this case study was that elders have reduced their dependence on family support. Less dependence on the family support was observed among insured elders. This does not mean the importance of the family is reduced. The reduced dependence due to the complementary roles of the formal care through health insurance improves family-based care. How does the elder using health insurance become less dependent on family support at the same time when family support is on the decline? The social constructionist perspective on aging was used in the case study to help explain this outcome.

The health insurance provides health care to elders and has relatively improved their health state due to increased access. An improved health state means less financial support and assistance at home. The healthier the elders are in old age, the less dependent they become. Moreover there was a decision power shift from primary caregivers to elders themselves. Elders decide on health care choices without waiting for support from their primary carers. The health insurance intervention had changed their wait-and-see behaviour to check-now attitude. In addition, it was observed that elders still have fewer resources and remain particularly dependent on their children for resources such as food, clothing, as well as housing. However, the health insurance takes off some of the items on the support list

which include medical cost. Elders save on medical expenses and resources are freed to cater for other necessities and they become less dependent on family support.

The modernisation and constrained resource perspective were also pulled into the discussion since both perspectives explain the declining role of the family to support elders. However in the modernization and constrained resource perspective, elders are labeled as passive agents in their explanation of the decline in family support. The modernisation and constrained resource explanations have not considered the change in behaviour that can occur towards support from families if other social resources were available to elders.

The social constructionist idea explains how health insurance as a structural policy intervention and elders as active agents interact with the scheme. It is the structure-agency interaction influencing significantly the decline of dependence on family support among elders. This includes financial, economic and physical dependence which was observed to be declining. This structure-agency interaction brings out the meaning of the decline in dependence in old age on family support. Elders as active agents, who are already not getting enough from their families, are falling on the health insurance intervention and through that reduce their reliance on the family. Elders who are poor and dependent can change when presented with other forms of social resources and demand less from their families that are already economically constrained.

The importance of the health policy intervention cannot be overstated to relegate family support and care to the background. Both social resources for elders can go hand-in-hand with other social resources to make elders more independent. The family is still needed since health insurance alone as mentioned earlier in the study cannot guarantee that there is decline in all the faces of dependence.

The study could have included all other social resources apart from their families that can make elders independent. Such a result can either confirm more or reduce the strength in this conclusion. However, this case study restricted the social resources to just the health insurance and little mention of formal social security. Further studies can include all other structural policy intervention to investigate similar goals in this case study.

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Appendix 1. Tables of analysis. Table 4.2: Background information

	Age	Gender	Marital status	No. of children	Occupation	SSNIT Contribution/benefits
Urban						
1	70	Male	Married	7	Retired	Receiving benefits since going on pension
2	71	Female	Married	none	Trader (buying and selling)	Never paid contributions nor received pension benefits
3	72	Female	Not married	3	Not working	Never paid contributions nor received pension benefits
4	76	Male	Not married	6	Retired (private company)	Paid contributions to pension scheme but has not received benefits yet.
Rural						
1	85	Male	Not married	4	Retired mason	Never paid contributions nor received pension benefits
2	83	Male	Separated	6	Retired civil servant	Receiving benefits since going on pension
3	94	Male	Not married	7	Not working (previously a farmer)	Never paid contributions nor received pension benefits
4	80	Female	Not married	9	Not working	Never paid contributions nor received pension benefits

Appendix 1, Table 4.3: Health insurance use and importance

	Living arrangements	Health insurance	Premium	Importance of health insurance	NHIS last used
Urban					
1	With wife and children	Yes	No	It is very important	Late last year (2011)
2	Alone (with maid)	Yes	Yes	It is very important and necessary	Last month
3	Alone (with maid)	Yes	Yes	Important and necessary	Can't remember
4	Alone	Yes	Don't remember	It was necessary and very important	It shouldn't be long but can't remember the last time
Rural					
1	Not alone - grandson and granddaughter	Yes	No	Very important and necessary	Two weeks before the interview
2	Alone	No	Don't remember	Knows health insurance is very important though	Don't remember
3	Not alone - sister and grandson	Yes	No	Very important	Past three weeks from the day of interview
4	daughter	Yes	Yes	Very important	Last month

Appendix 1, Table 4.4: Self-support and family support. Where symbols mean; (X) Not Able, * Able, and (barely)

	ADL/IADL	Frequency of help needed	Primary caretakers	Support and assistance from family
Urban				
1	Carrying things (X) Cleaning house (X) Can do all remaining ADL/AIDL on his own	Sometimes only for cleaning and renovation	Wife and children	Provide money for food Others things
2	Carrying things (X) Washing cloth (barely) Can do all remaining ADL/AIDL on her own	All the time (with activities she cannot do)	House helper	None
3	Can do all ADL/AIDL on her own	Not at all	Son	Pay rent Money for food Provide clothing Medical bills Other things
4	Can do all ADL/AIDL on his own	Sometimes	Sister	Other things

Rural				
1	Walking (barely) Washing (X) Cooking (X) Cleaning (X) Carrying things (X) Eating * Bathing * Dressing up*	All the time	Grandson and granddaughter	Provide food Provide clothing Medical bills Other things
2	Carrying things (X) Can do all other ADL/AIDL on his own	Only Sometimes	Niece	Provide food Other things
3	Walking (barely) Washing (X) Cooking (X) Cleaning (X) Carrying things (X) Eating * Bathing (X) Dressing up (X)	All the time	Elderly sister and grandson	Pay rent Provide food Provide clothing Medical bills Other things
4	Walking (barely) Washing (X) Cooking (X) Cleaning (X) Carrying things (X) Eating * Bathing (barely)	All the time	daughter	Pay rent Provide food Provide clothing Medical bills Other things

Appendix 1, Table 4.5: NHIS and changes in family support

	Health insurance as Social protection	Health insurance as Economic security	Health care needs/satisfaction	Changes in Support and care
Urban				
1	Yes	Yes	Almost all health care needs	Makes the children feel he is important and not dependent on children and wife at least in terms of financing health care. He can still save and help the children since there less medical charges.
2	Yes	Yes	Almost all health care needs	It does not make a difference for her.
3	Yes	Yes	Almost all health care needs	Less reliance on my children, not a burden to the children.
4	Yes	Yes	Almost all health care needs	Feel self-worth and not dependent. I can also pay for my sons fees when he is going to school.
Rural				
1	Yes	Yes	All health care needs take care of.	Decline in support from other family members. Sees the health insurance as more important and make him less dependent on grandchildren.
2	Yes (See the health insurance as protection)	Yes (See the health insurance as economic security)	All health care needs met.	Do not depend on any other person for support. Takes care of himself with the pension benefits he receives.
3	Yes	Yes	Almost all health care needs.	Less worry for elderly sister and grandson who are both not working
4	Yes	Yes	Almost all health care needs.	Less burden for my children

